Medigap insurance, more formally known as Medicare supplement insurance, is a vitally important product for beneficiaries who choose Medicare’s original fee-for-service (FFS) benefit design (Parts A and B). The Medicare FFS benefit provides coverage for medical benefits, but it does not limit a beneficiary’s out-of-pocket expenses. Medigap insurance provides coverage – at varying levels – for the significant out-of-pocket costs that are not covered by Medicare such as deductibles, coinsurance, and copayments. Working in tandem with Medicare, Medigap allows seniors and other beneficiaries—many of whom are on fixed incomes—to budget for medical costs and to avoid the confusion and inconvenience of handling complex medical bills from providers.

As Congress and policymakers debate changes to the Medicare program, they should carefully evaluate the impact of any reform proposals on the vulnerable populations who rely on Medigap insurance and consider the following facts.

**Myth #1:**

Medigap coverage increases unnecessary Medicare spending.

**Fact:**

Medigap carriers do not make medical necessity decisions or perform utilization review for health care services covered under the Medicare program. By federal law, Medigap carriers only pay benefits after Medicare has made a determination that the service is medically necessary and has paid its share for the benefits. Therefore, only the Medicare program itself can truly influence “unnecessary” spending at the point-of-service. Studies that identify a causal connection between the existence of supplemental coverage and higher utilization acknowledge that the analyses **do not** address the medical necessity of the services received. Researchers agree that a proportion of the increase in utilization may be due to the fact that those who purchase Medigap have higher medical needs.¹

**Myth #2:**

Taxing Medigap premiums or eliminating first-dollar Medigap coverage will reduce unnecessary Medicare spending.

Fact:
Consumer advocates caution against eliminating first-dollar coverage or imposing taxes on the premiums of seniors as a way to discourage the purchase of first-dollar coverage Medigap products. These policy changes may in fact reduce the use of necessary services. This would not only disproportionately harm the most vulnerable Medicare beneficiaries, but would also lead to higher costs to the system in the long run.\textsuperscript{234}

In 1984, RAND conducted the National Health Insurance Experiment (HIE) to study the effects of cost-sharing on health expenditures and patient outcomes. RAND found that for most populations, patients with zero cost-sharing had higher spending but, on average, similar health outcomes as patients with cost-sharing responsibilities. On behalf of America’s Health Insurance Plans (AHIP), two leading economists conducted research on the RAND HIE and the effects of higher cost-sharing on vulnerable subpopulations, and more specifically, on the Medicare population.

- The authors found that the RAND study only examined the effects of lower cost-sharing on the under-65 population. However, RAND found that patients with lower incomes and higher rates of chronic conditions – categories in which many Medicare beneficiaries would fall – had poorer outcomes when faced with higher cost-sharing.\textsuperscript{5}
- Furthermore, the authors found that a prohibition on first-dollar Medigap coverage may achieve some savings, but the resulting higher cost-sharing would likely reduce both medically necessary and medically unnecessary care. Reductions in medically necessary care result in more expensive treatments and worse health outcomes in the long run, which would lead to higher rather than lower Medicare expenditures.

Myth #3:
Only Medicare beneficiaries with high incomes can afford Medigap coverage.

Fact:
Medigap is particularly important to lower income and rural Medicare beneficiaries. It allows consumers on limited incomes to budget for their medical expenses in a way that

\textsuperscript{2} Ibid.
\textsuperscript{3} Doescher, MP et al. Supplemental Insurance and Mortality in Elderly Americans. Archives of Family Medicine, March 2000.
makes their out-of-pocket health care costs predictable throughout the year. In fact, in 2012, nearly half (49 percent) of rural Medigap policyholders and 40 percent of all Medigap policyholders had annual incomes below $30,000. As noted by the California Health Advocates, “people with low incomes and chronic illnesses, and those who live in rural areas rely most on Medigap coverage to manage their Medicare out-of-pocket costs. By preserving Medigap, we protect those who need comprehensive health coverage most of all.”

Myth #4:

Only healthy Medicare beneficiaries purchase Medigap.

Fact:
Research shows that on average, Medigap policyholders are more likely than the Medicare population as a whole to have one or more health care conditions. A detailed analysis of beneficiaries’ health status based on patient diagnosis found that Medigap enrollees are more likely than those only with Medicare coverage to have high-cost chronic conditions. Therefore, much of the difference in health costs between the two groups may stem from the difference in health status rather than differences in insurance coverage.

Percentage of Medicare Beneficiaries With One or More Health Conditions

![Graph showing the percentage of Medicare beneficiaries with one or more health conditions by age cohort.]

6 Medicare Current Beneficiary Survey Access to Care files, 2012 (CMS), (Analysis conducted in 2015).
9 Ibid.
Myth #5:

All Medigap policies provide first-dollar coverage.

Fact:
There are currently ten standardized Medigap policies for Medicare beneficiaries to choose from. All but two of these plans include some form of enrollee cost-sharing. The newer standardized plans requiring enrollee cost-sharing are the most rapidly growing Medigap plans. For example, the fastest growing Medigap product, Plan N, does not cover the Part B deductible and also requires copays for certain office and emergency room visits. Plan N was first introduced in June 2010 and year-to-year sales from 2010 to 2013 grew by 207% to over 573,000 enrollees. The next fastest growing Medigap plan, Plan G, does not cover the Part B deductible and grew by 60% during the same timeframe.

Fastest Growing Medigap Plans Have Cost-Sharing

Conclusion

Seniors purchase Medigap coverage in order to:
- Protect themselves from high out-of-pocket costs not covered by Medicare,
- Budget for medical expenses, and
- Avoid the confusion and inconvenience of handling complex bills.

Congress and policymakers should take great care to evaluate the impact of legislative proposals on existing and new Medigap beneficiaries.